State of Wisconsin
Department of Natural Resources

Infectious Waste Annual Report

Form 4400-177 (R12/2003)

NOTICE: This form is authorized by s.NR526.15, Wis. Adm. Code. Completion of this form is mandatory unless the facility is exempt under both ss.NR 526.14(2) and 526.16(2), Wis Adm. Code. Failure to submit a completed report to the Department of Natural Resources is punishable by a forfeiture of not less than $10 nor more than $5000 [s.299.97, Wis. Stats.]. Personally identifiable information on this form will be used for administering the Infectious Waste Program and is not intended to be used for any other purpose.

DO NOT SEND THE $55 FILING FEE NOW. You will be billed later.

Part I - Facility Information

Name of Infectious Waste Generator

Facility Identification No. (FID)

Report Year

Generator Location DO EXEMPTION STATUS BOX FIRST →

Street Address of Generator

City State Zip Code

County

Owner

Exemption Status Read instructions carefully

- ☐ Check if exempt from Part II. You may be required to report under Part III.
- ☐ Check if exempt from Part III. You may be required to report under Part II.
- ☐ Check if exempt from Parts II and III. Go to Part IV, sign and date the report, and send back to DNR.

Should DNR send you an annual report next year?

☐ Yes ☐ No If not, why not? _____

Generator Type -Check all that apply

- ☐ 170 Hospital
- ☐ 171 Nursing Home
- ☐ 172 Physician office or clinic
- ☐ 173 Dental office or clinic
- ☐ 174 Veterinary office or clinic
- ☐ 175 Clinical laboratory (freestanding)
- ☐ 176 Dialysis clinic (freestanding)
- ☐ 177 Other - Specify:_____

If you checked more than one, which one generated the most infectious waste?_____

Infectious Waste Type -Check all that apply

- ☐ W421 Sharps
- ☐ W422 Human tissue
- ☐ W423 Bulk blood and body fluids from humans
- ☐ W424 Microbiological laboratory waste
- ☐ W425 Tissue, bulk blood or body fluids from animals carrying zoonotic infectious agents

Infectious Waste On-site Activities -Total weights in reporting year

Please round up to nearest pound.

- **A.** Infectious waste generated on-site _____. lbs.
- **B.** Accepted from other Wisconsin generators _____. lbs.
- **C.** Accepted from out-of-state generators _____. lbs.
- **D.** Treated on-site _____. lbs.
- **E.** Transported off-site for treatment _____. lbs.

Part II - Off-Site Treatment Report

To be submitted by all infectious waste generators unless exempt.
Cross out any incorrect information and update it.

First off-site treatment facility name, from manifests

Treatment facility address

City State Zip Code

First Treatment facility DNR Facility Identification Number (FID)

Second off-site treatment facility name, from manifests

Treatment facility address

City State Zip Code

Second Treatment facility DNR Facility Identification Number (FID)

Report any additional treatment facilities on an attachment.

Manifest summary

- **H.** Total amount of infectious waste manifested _____. lbs.
- **I.** Amount of waste accounted for by return manifests _____. lbs.
- **J.** Total number of manifests not yet returned to generator _____

FOR DNR USE ONLY - LEAVE BLANK

Date Stamp - Date form was received

Items missing or incomplete:

Follow-up done (date, action, initials):

☐ Needs FID ☐ Needs folder

☐ Verify exemption ☐ Verified on:_____

☐ Exempt

☐ Non-exempt, complete

☐ Non-exempt, incomplete

Logged in _____ by_____

☐ Follow-up needed: __call __E-Mail __letter

☐ IW data complete, ready to enter

Log updated _____ by _____

SHWIMS data entered_____ by _____

IW data entered _____ by _____

Part III - MEDICAL WASTE REDUCTION PROGRESS REPORT

For all hospitals, clinics and nursing homes unless exempted from implementing medical waste reduction plans.

K. Medical waste generation rate. Calculate the rate using only one of the formulae below or your DNR-approved formula.

Hospitals and Nursing Homes

(1) Total from Line A (on reverse) _____ lbs.
F. Number of Patient-days _____ Pt.-day
K. Divide Line (1) by Line F __.__ __ lbs./Pt.-day

Dialysis Clinics

(1) Total from Line A (on reverse) _____ lbs.
FD. Number of Dialysis treatments _____ treatments
K. Divide Line (1) by Line FD __.__ __ lbs./trmt

Clinics

(1) Total from Line A (on reverse) _____ lbs.
G. Number of treatment areas _____ treatment areas
(2) Divide Line (1) by Line G __.__ __ lbs./treatment area
(3) Days in year 365 days
K. Divide Line (2) by Line (3) __.__ __ lbs./treatment area per day

Facilities with DNR-approved formula

K. Your formula calculates this rate ___ .__ __ (attach your calculations)

L. Medical waste policy
Date ____/____/_____ mm/dd/yyyy
Policy title _____

M. Medical waste reduction plan
Date ____/____/_____ mm/dd/yyyy
Plan title _____

N. If you revised the plan this year, list revision date(s): ____/____/_____ mm/dd/yyyy ____/____/_____ mm/dd/yyyy

O. Summary of medical waste reduction plan. Briefly summarize what you will do over the next 5 years. Answer all questions in the instructions for Line O.
Report year for which DNR last received a complete summary of your plan ☐

- Does that summary answer all questions in the instructions for line O?
  - ☐ Yes. Go to next question.
  - ☐ No. Attach a new summary which does answer all questions in the instructions.
- Has it been 5 years or more since you performed a waste audit, updated your plan, and sent DNR a complete summary?
  - ☐ Yes. Perform a waste audit, revise your plan and attach a new summary.
  - ☐ No. You don't need to submit a summary this year.
- If summary is attached, are the generator's name, facility ID number (from top of Part I) on the attachment?

For DNR use only	
Summary needed?	___yes ___no
Summary attached?	___yes ___no
Summary complete?	___yes ___no
Progress report attached?	___yes ___no
Progress report complete?	___yes ___no

P. Description of progress. Briefly describe what you did during the reporting year to implement your plan's goals and objectives. Attach one additional sheet which answers all the questions in the instructions for Line P.

PART IV - CERTIFICATION

Authorized Contact Name

Mailing Address

City, State, Zip Code

Telephone Number

Electronic mail (Email) address

How do you prefer to be contacted if DNR has questions?
☐ Telephone ☐ Mail ☐ Email

DNR will send the invoice for the filing fee to the contact person above.

I certify that to the best of my knowledge, the above information and attachments are true and correct.

Name of Director (Building manager or top administrator for this location)

Title

Signature of Director
X Date Signed(mm/dd/yyyy) _ _ /_ _/_ _ _ _

☐ Check here if form is submitted for a group of generators in the same location which manage their wastes together. Provide Part IV information, signature and date for each member of the group.

HOW TO SUBMIT FORM: Copy signed form and attachments for your records. Submit original signed form and attachments to:

Medical Waste Coordinator
DNR Bureau of Waste Management
P.O. Box 7921
Madison, WI 53707-7921

Send no money now. You will be billed for the $55 filing fee.